This Practitioner Services HMO Agreement ("Agreement") is made by and between Wellmark Health Plan of Iowa, Inc. (hereinafter "HMO"), and the provider identified on the signature page (hereinafter "Provider").

RECITALS

1. HMO is authorized by the Iowa Division of Insurance to transact business as a health maintenance organization and is licensed by the Blue Cross and Blue Shield Association.

2. HMO, on behalf of itself and: (i) state and federal programs administered by HMO, (ii) any licensed subsidiary or affiliate of the Blue Cross and Blue Shield Association and licensed Blue Cross and Blue Shield Plans, and (iii) HMO's Affiliates, wishes to secure the health care services of providers for HMO's Covered Persons and for the covered persons and products of the other programs and entities set forth above.

3. Provider desires to make health care services available to HMO’s Covered Persons and the covered persons and products of the other programs and entities set forth in Recital 2 for the purposes specified in this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the parties hereto agree as follows:

ARTICLE I
DEFINITIONS

1.1 “Affiliate” of a party to this Agreement means any entity that now or hereafter: (i) is owned or controlled (directly or indirectly) by such party to this Agreement, (ii) owns or controls (directly or indirectly) any such party to this Agreement, or (iii) is under common control with such party to this Agreement. "Affiliate" also includes an Affiliate of an Affiliate.

1.2 “Agreement” means this Agreement, as amended, all Exhibits attached hereto, the Provider Guide as made available to Provider, and any other documents specifically incorporated into this Agreement by reference. The Exhibits attached to this Agreement and made a part hereof by this reference at the time of initial execution are as follows:

   Exhibit A:       Payment Methodology
   Exhibit B:       Wellmark Networks
   Exhibit C:       Web-Based Access

1.3 "Contract" means the benefit certificate, policy or other written documents setting forth the health care benefits the Covered Person is eligible to receive.

1.4 "Covered Person" means any eligible employee, individual or group member, and any eligible sponsored dependent, entitled to receive Covered Services according to the terms and conditions of this Agreement and pursuant to an applicable Contract.

1.5 "Covered Services" means those health care services or supplies to which a Covered Person is entitled pursuant to a Contract, or, HMO, pursuant to an applicable law, is required to provide the Covered Person with benefits that are not otherwise covered under the applicable Contract.

1.6 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an
average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

(b) Serious impairment to bodily function; or

(c) Serious dysfunction of any bodily organ or part.

1.7 “HMO” means Wellmark Health Plan of Iowa, Inc.

1.8 “Medically Necessary” or “Medical Necessity” means Covered Services that a physician, exercising prudent clinical judgment, would provide to a Covered Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Person's illness, injury or disease; and (c) not primarily for the convenience of the Covered Person, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, injury or disease.

1.9 “Network” means the provider network(s) used by HMO in support of the Products in which the Provider participates as a HMO provider as identified on Exhibit B to this Agreement.

1.10 “Participating Provider” means a provider who has entered into a provider agreement with HMO whereby such provider has agreed to provide health care services to HMO’s Covered Persons and the covered persons of the programs and entities set forth in Recital 2.

1.11 “Product” means a health benefit plan offered or administered by HMO that utilizes one of the Networks identified on Exhibit B. The Products shall be listed on HMO’s website, which list may be updated or modified from time to time by HMO.

1.12 “Provider” means the provider who is identified as such on the signature page of this Agreement. If Provider is a professional corporation (“PC”), professional limited liability company (“PLLC”) or other legal entity, “Provider” means: (i) the PC, the PLLC or the other legal entity, as the case may be, and (ii) the person who is licensed, certified or otherwise authorized by a governmental entity to carry on the profession on behalf of the PC, the PLLC or the other legal entity.

1.13 “Provider Guide” means the HMO documents (guides and/or manuals), and all attachments thereto, incorporated herein by this reference, and as amended from time to time, made available to Provider that set forth applicable HMO administrative/operational policies, rules and procedures.

1.14 “Quality Improvement” means measuring, evaluating and improving the quality of Covered Services provided to Covered Persons by Provider.

1.15 “Utilization Management” means the review and determination on prospective, concurrent and retrospective bases of the Medical Necessity of Covered Services provided to Covered Persons and individuals covered by another licensee of the Blue Cross and Blue Shield Association (a “Blue Cross and/or Blue Shield Licensee”) pursuant to the terms and conditions of this Agreement.
ARTICLE II
SCOPE OF AGREEMENT

2.1 Applicability. This Agreement applies to those Networks that are established or administered by HMO as set forth on Exhibit B, as may be updated or modified by HMO from time to time.

HMO and the Provider agree that Provider will also provide health care services, as set forth in this Agreement, for the benefit of Covered Persons enrolled in or covered by the following programs and entities: (i) state and federal programs administered by HMO; (ii) any Blue Cross and/or Blue Shield Licensee; and (iii) HMO’s Affiliates.

Provider shall be able to obtain information on HMO’s website (www.Wellmark.com) describing benefits for each Product.

2.2 Construction. This Agreement shall be construed together with the terms and conditions of Contracts and Products subject to this Agreement; provided, however, that in the event of conflict, the terms of this Agreement shall govern.

ARTICLE III
RELATIONSHIP BETWEEN HMO AND PROVIDER

3.1 Independent Contractors. HMO and Provider are independent contractors under this Agreement with respect to each other. Nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee, principal and agent, joint venturers, or any relationship other than that of independent entities contracting with each other solely for the purpose of carrying out the terms and conditions of this Agreement. Neither party shall have any express or implied right or authority to assume or create any obligation or responsibility on behalf of, or in the name of, the other party; except as set forth herein.

3.2 Blue Cross and Blue Shield Disclosure. Provider hereby expressly acknowledges Provider's understanding that this Agreement constitutes a contract between Provider and HMO, that HMO is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting HMO to use the Blue Cross and Blue Shield Service Marks in the State of Iowa, and that HMO is not contracting as an agent of the Association. Provider further acknowledges and agrees that Provider has not entered into this Agreement based upon representations by any person other than HMO and that no person, entity or organization other than HMO shall be held accountable or liable to Provider for any of HMO's obligations to Provider created under this Agreement. This paragraph shall not create any obligations whatsoever on the part of HMO other than those obligations created under other provisions of this Agreement.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES

4.1 By HMO. HMO represents and warrants to Provider that: (a) HMO possesses and agrees to maintain during the term of this Agreement all licenses, permits, registrations, governmental and other approvals required to carry out its obligations pursuant to the terms of this Agreement; (b) this Agreement is authorized by all necessary corporate action on behalf of HMO, is duly executed and delivered by HMO, constituting a legal and binding obligation upon HMO; and (c) HMO shall comply with relevant federal, state and local laws, statutes, ordinances, orders and regulations which are applicable to the terms and conditions of this Agreement.

4.2 By Provider. Provider represents and warrants to HMO that: (a) the information furnished by Provider on and in connection with Provider's application and all updates thereto is and shall remain true, correct and complete with no material omissions at all times during the term of this Agreement; (b) Provider now possesses, and during the term of this Agreement shall maintain, all
professional licenses, accreditations, certifications, permits, registrations, governmental and other approvals required in order to provide the Covered Services; (c) Provider shall comply with relevant federal, state and local laws, statutes, ordinances, orders and regulations which are applicable to the terms and conditions of this Agreement; (d) if Provider is an entity, then Provider is duly organized and validly existing under the laws of the state of its organization, as applicable, with full power and authority to engage in practice as currently conducted; and (e) this Agreement has been authorized by all necessary action on behalf of Provider, is duly executed and delivered, and constitutes a legal and binding obligation of Provider.

ARTICLE V
HMO

5.1 Medical Necessity; Experimental or Investigational. A physician designated by HMO will make the determination on behalf of HMO whether health care services are Medically Necessary, or experimental or investigational in nature.

5.2 Acceptance and Credentialing of Provider. At all times during the term of this Agreement, Provider shall meet the HMO contracting and credentialing standards set forth in the Provider Guide. HMO retains sole discretion to determine whether Provider shall be accepted as a Participating Provider pursuant to HMO's policies, rules, procedures and contracting and credentialing standards.

5.3 Rights Reserved to HMO. HMO reserves the right to communicate directly with Provider on any subject matter. HMO may decline, limit, or suspend the participation of Provider under this Agreement, or terminate this Agreement, under circumstances including, but not limited to, the following: (a) termination, suspension, limitation, voluntary surrender or restriction of Provider’s or Provider’s Affiliate’s professional license, accreditation, certification, permit, or other governmental authorization; (b) if applicable to Provider or Provider’s Affiliates, any hospital disciplinary action or termination, suspension, limitation or restriction of professional staff appointments or clinical privileges; (c) failure to maintain any insurance as required herein; (d) Provider’s or Provider’s Affiliate’s conviction of a felony or any other criminal charge; (e) any disciplinary action taken by a state licensing board, the Drug Enforcement Agency ("DEA"), if applicable, or other governmental agency; (f) Provider’s or Provider’s Affiliate’s suspension or exclusion from participation in the Medicare or Medicaid programs; (g) any other legal, governmental or other action or event which may materially impair the Provider’s ability to perform any duties or obligations under this Agreement; or (h) HMO believes Provider does not meet or no longer meets HMO’s contracting or credentialing standards set forth in the Provider Guide.

Consistent with the “Provider Denial, Termination, Appeal and Reporting Procedure” ("Procedure") set forth in the Provider Guide, should HMO believe termination of this Agreement is warranted at any time after Provider has been accepted as a Participating Provider hereunder, it shall so notify Provider and advise Provider of Provider’s right to appeal the proposed adverse action; provided, however, that the Procedure is only applicable to certain individual health care practitioners (not to legal entities), and is only applicable if termination is based on competence or professional conduct. HMO may immediately suspend or limit Provider’s participation in any or all Contracts where the failure to take such immediate action could, in HMO’s judgment, result in imminent danger to the health of any Covered Person. In the event this Agreement is terminated because Provider fails to maintain professional licensure, accreditation, certification, a permit, or other governmental authorization required to provide Covered Services, Provider shall have no right to a hearing or an appeal under the Procedure concerning such termination.

In the event Provider’s participation is declined, limited, or suspended, or this Agreement is terminated, as provided above, Provider will immediately notify Provider’s patients of such decline, limitation, suspension or termination.
ARTICLE VI
PROVIDER RESPONSIBILITIES

In addition to the other duties of Provider under this Agreement, Provider agrees as follows:

6.1 **Provider’s Notices.** Provider shall notify HMO, in writing, within fifteen (15) business days of: (a) any termination, suspension, limitation, voluntary surrender or restriction of Provider’s professional license, accreditation, certification, permit, or other governmental authorization; (b) if applicable to Provider, any hospital disciplinary action or termination, suspension, limitation or restriction of professional staff appointment or clinical privileges; (c) failure to maintain any insurance as required herein; (d) Provider’s conviction of a felony or any other criminal charge relating to Provider; (e) any disciplinary action taken by a state licensing board, the DEA, if applicable, or other governmental agency; (f) Provider’s suspension or exclusion from participation in the Medicare or Medicaid programs; or (g) any other legal, governmental or other action or event which may materially impair the Provider’s ability to perform any duties and obligations under this Agreement.

6.2 **Provide Covered Services.** Upon presentation by a Covered Person of an HMO-issued or administered identification card stating the Covered Person’s identification number or, pursuant to HMO’s telephonic or electronic verification (or other means of verification hereafter established by HMO from time to time) of a Covered Persons’ eligibility, Provider will provide Covered Services in accordance with the terms of this Agreement with the same quality and accessibility in terms of timeliness, duration and scope as is provided to Provider’s other patients. All Covered Services provided by Provider will be Medically Necessary. Further, Provider shall not discriminate against Covered Persons based upon their status as Covered Persons, their age, sex, race, religion, national origin, creed, color, physical or mental disability, political belief or health status. Provider shall, unless medically contraindicated or in a situation requiring emergency services to evaluate or stabilize an Emergency Medical Condition, refer Covered Persons to another provider designated as a Participating Provider by HMO in the event that Provider cannot provide the type of Covered Services required by the Covered Person.

6.3 **Blue Cross and Blue Shield Out-of-Area Program.** Provider shall provide covered services to any person covered by another licensed Blue Cross and Blue Shield Plan (“Plan”) under the Blue Cross and Blue Shield Association’s out-of-area or reciprocal programs and to submit claims for payment to HMO for HMO’s coordination with the appropriate Plan in adjudicating the claim according to the person’s benefit contract. The provisions of this Agreement shall apply to charges for covered services under the Blue Cross and Blue Shield out-of-area and reciprocal programs. Provider shall accept reimbursement by HMO as payment in full for covered services provided to such persons except to the extent of deductibles, coinsurance and/or copayments.

6.4 **Participate in Complaint Resolution.** Provider shall participate in such complaint procedures as HMO may put into effect to address the complaints of Covered Persons provided, however, that compliance with this Section shall not include the provision of information protected by Iowa Code sections 135.40-42 and 147.135 or responding to allegations of medical malpractice or other claims that could result in damage awards against Provider.

6.5 **Health Management.** The Utilization Management and Quality Improvement programs shall be set forth in the Provider Guide. Provider shall cooperate in carrying out all duties specified in the Utilization Management and Quality Improvement programs consistent with applicable Contracts.

HMO may, at its discretion, request Provider’s participation in the development and/or ongoing review and oversight of the Utilization Management and Quality Improvement programs through Provider representation on various health management committees which may be established from time to time by HMO. The mechanism for appointment to and responsibilities of the health management committees are set forth in the Provider Guide.
6.6 **Information Requests.** Provider shall furnish information as requested, in accordance with relevant state and federal laws, including, but not limited to, the medical records of Covered Persons and Health Plan Employer Data and Information Set reporting, to support HMO quality initiatives and performance. Ownership of all such information (except for the medical records) shall vest exclusively in HMO. Provider shall obtain from the Covered Persons any consents and authorizations necessary in order to provide such records and information to HMO.

6.7 **Compliance with Administrative/Operational Policies.** Provider shall comply with the administrative/operational policies, rules, procedures and protocols set forth in the Provider Guide, as adopted and amended from time to time by HMO, and as made available to Provider. Non-material changes to the Provider Guide may be made from time to time by HMO without amendment of this Agreement. Material changes, adverse to Provider, to the Provider Guide may be made from time to time by HMO by amendment of this Agreement as provided in Section 14.9 of this Agreement.

6.8 **Periodic Evaluation.** Provider shall cooperate with HMO’s periodic evaluation of Provider’s professional qualifications, which shall include, but not be limited to, Provider giving consent to the release of information from any hospital at which Provider has medical staff privileges.

### ARTICLE VII

**HMO RESPONSIBILITIES**

In addition to the other duties of HMO under this Agreement, HMO agrees as follows:

7.1 **Provider Guide.** In conjunction with the initial delivery of this Agreement to Provider, HMO will make available a Provider Guide to Provider. The Provider Guide will be updated on a regular basis and supplemented with communications as needed to reflect changes in benefits and any other administrative/operational policies, including Quality Improvement and Utilization Management policies, with which Provider must comply as a condition of participation.

7.2 **Benefit Differentials, Limited Networks and Incentive Programs.** Benefits under Contracts, including Covered Persons’ copayments, deductibles, and/or coinsurance amounts may vary between Contracts and change from time to time. HMO or a sponsor of a group health plan administered by HMO may establish incentives in the Contracts for Covered Persons to receive Covered Services from Participating Providers or from a limited network or other grouping of Participating Providers. HMO may utilize networks limited to eligible Participating Providers with financial or other incentive programs for Covered Persons to use the services of providers contracting with HMO other than Provider. Provider may not be eligible for such networks and programs, and such networks and programs may not be offered to all Participating Providers (including Provider). Such networks and programs may include, but are not limited to: networks limited to eligible providers; networks designed for a specific plan sponsor of a group health plan; programs for specialty Covered Services; variances among copayments, deductibles and/or coinsurance; varying payment arrangements among providers; provider training/coaching programs; and programs that attempt to support the improvement of the quality of Covered Services (participation in which programs may be publicly disclosed, as well as the levels achieved in such programs).

7.3 **Administrative Responsibilities.** HMO will perform or arrange for the performance of all administrative responsibilities necessary under this Agreement for the provision of Covered Services to Covered Persons except as otherwise specified herein. Administrative responsibilities performed by HMO pursuant to this Agreement may include, but are not limited to, the following: (a) enrollment; (b) premium collection; (c) claims processing; (d) customer service; (e) provider network development; and (f) health management functions.
7.4 **Data Reporting and Information Requests.** HMO may provide, in a format and media mutually acceptable to the parties, periodic reports to Provider regarding utilization and cost of Covered Services provided to Covered Persons by Provider subject to this Agreement. To the extent permitted by law, HMO will attempt to respond to other data/information requests from Provider as HMO deems appropriate.

**ARTICLE VIII**

**PAYMENT FOR COVERED SERVICES**

8.1 **Payment.** Subject to the terms and conditions of this Agreement, HMO will make payment to Provider in accordance with the terms and conditions of the applicable provisions of Exhibit A.

8.2 **Source of Payment.** Except as expressly provided herein, Provider agrees to: (a) accept payment made by HMO as full payment for Covered Services furnished to Covered Persons except to the extent of deductibles, coinsurance and/or copayments; (b) not bill Covered Persons for any balance attributable to Covered Services other than deductibles, coinsurance and copayments; and (c) seek payment from Covered Persons for any such deductibles, coinsurance and/or copayments. Provider may seek payment from Covered Persons for other services not covered under the applicable Contract except that Provider may only seek payment in accordance with Section 8.5 of this Agreement for services determined not to be Medically Necessary. Furthermore, if applicable under the Covered Person's Contract, Provider may not seek payment from Covered Person for any Covered Services rendered as a specialty care provider in the absence of a referral from the Covered Person's primary care provider unless before rendering such services the specialty care provider informs the Covered Person, in writing, that the services rendered are not considered Covered Services under the applicable Contract absent a referral from the Covered Person's primary care provider.

In the event the plan sponsor of a self-funded group health plan administered by HMO becomes insolvent or refuses to provide adequate funds to HMO for the payment of claims, Provider may seek payment for such claims directly from the self-funded group health plan sponsor or the Covered Person. Provider agrees that should the plan sponsor of a self-funded group health plan become insolvent or fail to remit adequate funds for payment of such claims HMO shall have no obligation to make payment to Provider for such claims and that Provider's sole recourse shall be against the self-funded group health plan sponsor or the Covered Person.

8.3 **Utilization Management Procedures.** Provider will follow HMO's Utilization Management procedures set forth in the Provider Guide with respect to the specified services identified in such Provider Guide. Provider will not attempt to collect from Covered Persons any payment reduction resulting from Provider's failure to follow such procedures.

8.4 **Claims Filing and Claims Adjustments.** Provider shall submit claims on behalf of Covered Persons in a manner and format acceptable to HMO and as prescribed from time to time by HMO. Claims shall be submitted by electronic means in standard electronic formats acceptable to HMO when feasible under the circumstances.

For Provider to be paid for Covered Services furnished to a Covered Person, the claim for such Covered Services must be received by HMO within one hundred eighty (180) days immediately following: (i) the date the Covered Service was furnished to the Covered Person when HMO is the primary payor, or (ii) if HMO is the secondary payor, the date of the primary payor's explanation of benefits (or if the primary payor does not issue an explanation of benefits, then the date of the primary payor's remittance advice). HMO may extend the one hundred eighty (180) day time period for a reasonable period, on a case-by-case basis, if Provider provides written notice to HMO, along with appropriate evidence (as determined by HMO), of circumstances reasonably beyond Provider's control (as determined by HMO) that resulted in the delayed submission. Provider shall not bill Covered Persons for Covered Services associated with any claim Provider fails to submit within such one hundred eighty (180) day period.
If, under this Agreement or any of its Exhibits, it is determined that HMO has made payment to Provider in error, HMO may deduct from future payments due to Provider amounts equal to the amount of payment or payments made in error or may recover payments directly from Provider for such payment or payments made in error; provided, however, that HMO may not initiate deductions from future payments due to Provider or initiate efforts to recover payments directly from Provider with respect to a claim more than eighteen (18) months after the date of HMO’s original remittance advice with respect to such claim, except that no such time limit will apply to HMO’s recovery efforts: (i) based on HMO’s reasonable belief of fraud or other intentional misconduct, (ii) required by a self-insured employer or group sponsor, or (iii) required by a state or federal government program. If Provider asserts a claim for an underpayment, HMO may defend or set off such claim based on payments made in error to Provider, and may go back in time as far as the claimed underpayment. If it is determined by HMO that an underpayment has been made to Provider, HMO will make a payment adjustment in that amount to Provider; provided, however, that HMO shall not make a payment adjustment with respect to a claim unless HMO becomes aware of such underpayment within eighteen (18) months from the date of HMO’s original remittance advice with respect to such claim.

8.5 **Payment by Covered Persons.** Provider shall have the right to seek payment from a Covered Person for services rendered to the Covered Person which have been determined not to be Medically Necessary or which have been determined to be investigational or experimental, provided that, prior to rendering such services, the Provider provides the Covered Person with advance written notice that: (i) identifies the proposed services, (ii) informs the Covered Person that such services may be deemed by HMO (or have been deemed by HMO, as the case may be) to be not Medically Necessary or to be experimental or investigational, and (iii) provides an estimate of the cost to that Covered Person for such services and the Covered Person agrees in writing in advance of receiving such services to assume financial responsibility for such services.

Provider, or its assignee or subcontractor, hereby agrees that in no event including, but not limited to, nonpayment by the HMO, the HMO insolvency or breach of this Agreement, shall Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or persons other than the HMO acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of coinsurance, copayment and deductible amounts, if applicable, in accordance with the Contract under which a Covered Person is eligible to receive services.

Provider, or its assignee or subcontractor, further agrees that: (a) the provisions in this Section shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person; and (b) the provisions in this Section supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Covered Person or persons acting on their behalf.

8.6 **Claims Encounter Data.** Provider shall: (a) furnish on request all information reasonably required to verify and substantiate the provision of Covered Services; and (b) not charge HMO or a Covered Person for any expenses associated with Provider’s compliance with HMO’s requirements for information to enable HMO to process claims.

8.7 **Coordination of Benefits.** Provider shall cooperate, to the extent permitted by law, with HMO’s coordination of benefits efforts, providing to HMO such information as Provider may obtain regarding other payors, primary or other than primary, with respect to a particular Covered Person. Payments made to Provider by HMO and/or a Covered Person pursuant to this Agreement shall be based upon payment methodologies described in this Agreement regardless of whether HMO is the primary payer for the Covered Person.
8.8 **Subrogation.** Provider shall cooperate, to the extent permitted by law, with HMO’s efforts regarding subrogation by providing to HMO such information as the Provider may obtain regarding other payors.

8.9 **Liens.** In the event Provider is entitled to assert a lien upon any recovery or sum collected or to be collected by a Covered Person or the Covered Person’s heirs or personal representatives in the case of Covered Person’s death, Provider shall furnish HMO with a copy of any lien filed within thirty (30) days of the filing thereof.

8.10 **Time for Payment.** HMO shall promptly pay Provider's "clean claims" (as defined by applicable statute) for Covered Services within thirty (30) days of receipt by HMO. A description of the information necessary for claims processing is set forth in the Provider Guide.

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**ARTICLE IX**

**MARKETING, ADVERTISING AND PUBLICITY**

9.1 **Use of Provider’s Name and Other Identifying Data.** HMO shall have the right to use Provider’s name and other identifying data concerning Provider for the purposes of publishing online or printed Participating Provider directories, marketing, informing Covered Persons of the identity of the Products, Networks, and Participating Providers, and as necessary to carry out the terms of this Agreement. HMO shall have the right to publish or otherwise disseminate ratings, recognition programs, and performance data related to Provider that may be provided by Covered Persons or may be the result of a Blue Cross and Blue Shield Association program, a national, regional, state, or local program, or as determined by HMO from time to time. Provider shall have the right to review marketing materials prepared by HMO that specifically reference Provider and may request revision to the extent Provider reasonably believes such marketing materials are inaccurate, incomplete or carry a material risk of liability for Provider. Except as otherwise provided in this Section 9.1, nothing herein shall permit HMO to use any symbols, service marks, trademarks or trade names of Provider without the written approval of Provider.

9.2 **Use of HMO Name.** Provider shall have the right to use the name of HMO as necessary to carry out the terms of this Agreement. Nothing herein shall permit Provider to use any symbols, service marks, trademarks or trade names of HMO without the prior written approval of HMO. Provider shall cease any such permitted usage immediately: (i) upon notice from HMO, and (ii) upon termination of this Agreement. HMO shall have the right to prior review and approval of any use of the name "Wellmark, Inc.,” “Wellmark Health Plan of Iowa, Inc.,” or any derivative thereof.

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**ARTICLE X**

**RECORDS, CONFIDENTIALITY AND AUDIT**

10.1 **Product Data.** All information and data collected or developed by HMO related to claims, cost, utilization, outcomes, quality and financial performance under the health benefit plans offered or administered by HMO during the term of this Agreement shall be referred to as "Product Data." Any Product Data that relates to services of a specific provider to a specific Covered Person shall be referred to as “Provider Specific Product Data.” HMO shall be the owner of all Product Data and all Provider Specific Product Data. Product Data provided to Provider by HMO shall be kept confidential by Provider and used only for the purpose of carrying out Provider’s obligations under this Agreement. Upon termination of this Agreement, Provider shall return to HMO any Product Data that is not Provider Specific Product Data.

To the extent permitted by law, HMO reserves the right to disclose (during the term and after termination of this Agreement) information derived from the Provider Specific Product Data to persons, including, but not limited to, a current or prospective Covered Person, a current or prospective employer or sponsor of a group health benefit plan, an auditor or health care consultant of a current or prospective employer or sponsor, providers participating in HMO’s Accountable Care Organization (“ACO”) program or other programs sponsored by HMO, or other
persons for permissible purposes. Such information may explicitly or implicitly identify Provider and include, but not be limited to, actual or projected payment levels made to Provider.

10.2 **Records.** Provider shall prepare and maintain, in accordance with prudent record-keeping procedures, and as required by applicable federal and state law, legible medical, financial and other records and data with respect to Covered Services rendered by Provider under this Agreement. Ownership of and access to medical records of Covered Persons are governed by applicable state and federal laws and this Agreement. Provider shall obtain from the Covered Persons any consents and authorizations necessary in order to provide such records and information to HMO. Subject to privacy and confidentiality requirements, the records of a Covered Person (and the information contained therein) shall be available to HMO (during the term and after termination of this Agreement) upon reasonable request by HMO.

10.3 **Mental Health Records.** Pursuant to Iowa Code chapter 228, HMO will file and maintain a confidentiality statement with the Iowa Commissioner of Insurance.

10.4 **Release of Information.** Provider agrees that: (i) all information provided to HMO by Provider, or (ii) otherwise obtained by HMO in connection with Provider’s application for participation or pursuant to Quality Improvement review, peer review, Utilization Management review, provider profiling or other review or audit of Provider’s practice conducted by or on behalf of HMO, may be released or disclosed to: (a) HMO’s Affiliates; and (b) the Provider to whom the information relates; or (c) a provider participating in the HMO ACO program or other programs sponsored by HMO in which Provider participates. Provider shall, if requested by HMO, complete HMO’s standard confidentiality/hold harmless agreement preceding the release to Provider of the information contemplated by this Section.

10.5 **Office and Record Audit.** Provider shall provide access to HMO representatives to perform office audits and medical record reviews during normal business hours. Provider shall give access to HMO to all records and documents reasonably related to the obligations of Provider under this Agreement. HMO will attempt to notify Provider, in writing, thirty (30) days in advance of routine office audits and medical record reviews, but reserves the right, when necessary in the judgment of the HMO, to conduct audits and reviews pursuant to advance notice of less than thirty (30) days.

10.6 **Website Access.** HMO may provide Provider with secured access to HMO’s website or web-based applications for Provider to obtain information regarding eligibility and claims for Covered Persons or for the purpose of self service. If Provider or a third party acting on Provider’s behalf accesses such websites or information, Provider is subject to and agrees to all security restrictions and user requirements imposed by HMO, as more fully described in Exhibit C to this Agreement and in the applicable Terms and Conditions posted at HMO’s website (www.Wellmark.com).

10.7 **Confidential Information.** In addition to the confidentiality provisions set forth elsewhere in this Agreement, the parties agree that all financial terms and conditions of this Agreement are confidential and neither Provider, its employees or agents, nor HMO shall disclose such terms and conditions without the prior written consent of the other party to this Agreement. In the event that either party, or any of its representatives, is requested or required in legal proceedings to disclose the financial terms or conditions of this Agreement, consent is not required; however, the disclosing party shall provide the other party with prompt written notice of any such request or requirement to the extent feasible under the circumstances. The form of agreement, without specific provider identifiable or payment information, is not confidential.

Provider shall maintain the confidentiality of fee schedules, payment arrangements, payment manuals, enrollment information, utilization data, quality management programs, and credentialing criteria. Provider shall not disclose such information to any third party without the prior written consent of HMO.
Such confidentiality shall be maintained to prevent unauthorized disclosure and to operate in accordance with applicable laws. This provision shall survive the termination of this Agreement. Nothing in this Section or in this Agreement is intended to prohibit Provider from disclosing to Covered Persons information about this Agreement or the Covered Person’s benefits that may affect the health or decisions regarding the health of such Covered Persons.

ARTICLE XI
INSURANCE AND LIABILITY

11.1 Insurance.

(a) Coverage. Each party agrees to carry professional liability insurance (claims-made with appropriate tail coverage or occurrence-based), at its own expense, in an amount of not less than $1,000,000 per occurrence and $1,000,000 aggregate, covering any claims with respect to Covered Services which may arise out of an incident occurring during the term of this Agreement. Such insurance shall include coverage for claims in connection with the performance of each party’s respective responsibilities under this Agreement. Provider shall furnish to HMO at the time Provider signs this Agreement, and from time to time thereafter as requested by HMO, proof of such insurance, which proof will include the name of the carrier, effective dates of coverage and coverage amounts.

(b) Notice of Claims. Provider shall promptly notify HMO whenever Provider learns that a Covered Person has filed a claim or notice of intent to commence a claim against Provider in connection with Covered Services. Upon request, Provider shall provide full details to HMO, to the extent of Provider’s knowledge, regarding the nature, circumstances and disposition of such claims.

11.2 Liability.

(a) Liability of HMO. HMO shall not be liable for any claims, damages, losses or expenses resulting from any injury or death of persons, damage to property or other form of injury arising from the alleged malpractice, negligence, breach of contract or other act of Provider or any of Provider’s employees, representatives or agents relating in any way to the performance or omission of any act or responsibility of Provider under this Agreement.

(b) Liability of Provider. Provider shall not be liable for any claims, damages, losses or expenses resulting from any injury or death of persons, damage to property or other form of injury arising from the alleged malpractice, negligence, breach of contract or other act of HMO or any of HMO’s employees, representatives or agents relating in any way to the performance or omission of any act or responsibility of HMO under this Agreement.

ARTICLE XII
CONTRACT TERM AND TERMINATION

12.1 Term. The term of this Agreement commences upon the date of acceptance of this Agreement by HMO and shall continue until terminated in accordance with Section 12.2.

12.2 Termination. This Agreement:

(a) shall terminate in the event HMO dissolves or Provider dies (if Provider is an individual) or dissolves (if Provider is an entity); or

(b) shall be terminated upon sixty (60) days written notice in the event of a material breach in the performance of the terms and conditions of this Agreement, which breach, upon
written notice by the non-breaching party to the party in breach, remains uncured by the party in breach at the end of the sixty (60) day notice period; or

(c) may be terminated by either party with or without cause upon one hundred twenty (120) days advance written notice to the other party; or

(d) may be terminated by HMO immediately upon written notice to Provider in the event of termination under Section 5.3; or

(e) may be terminated by Provider as provided in Section 14.9.

Notice of termination shall be given in accordance with Section 14.4 of this Agreement.

12.3 **Obligations During Termination Period.** In the event this Agreement is terminated pursuant to (b), (c) or (e) in Section 12.2 above, Provider shall continue providing Covered Services to Covered Persons throughout the Termination Period in accordance with all prevailing standards of care and applicable professional ethical canons. For purposes of this Agreement, "Termination Period" is defined to mean that period of time beginning with the date of written notice of termination pursuant to Sections 12.2 or 14.9, and concluding with the effective date of termination. Covered Services provided during the Termination Period shall be reimbursed in accordance with the terms and conditions of Exhibit A.

12.4 **Post Termination.** Upon termination of this Agreement, Provider shall no longer be entitled to designation as a Participating Provider. Provider shall return all HMO promotional materials to HMO and take those steps that may be reasonably required by HMO for Provider to be disassociated from HMO including, but not limited to, notifying Provider's patients that Provider is no longer a Participating Provider.

ARTICLE XIII
NON-EXCLUSIVITY

13.1 **Provider.** Nothing herein shall preclude Provider from contracting with other health insurance companies, health maintenance organizations or other entities licensed to assume health insurance risk.

13.2 **HMO.** Nothing herein shall preclude HMO from contracting with other providers to provide Covered Services to Covered Persons.

ARTICLE XIV
MISCELLANEOUS

14.1 **Assignment.** No assignment of the rights, duties or obligations of this Agreement shall be made by HMO or Provider without the consent of Provider or HMO, respectively.

14.2 **Waiver.** Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

14.3 **Entire Agreement.** This Agreement, all Exhibits hereto, and the Provider Guide constitute the entire Agreement between the parties with respect to the subject matter hereof, and all prior and concurrent agreements, understandings, representations and warranties, whether written or oral, in regard to the subject matter hereof including, without limitation, any provider agreement previously entered into with HMO concerning the Contracts subject to this Agreement by or on behalf of Provider, are hereby superseded; provided, however, this Agreement does not supersede any: (i) Medicare Advantage provider agreement, (ii) provider agreement concerning TriCare beneficiaries, or (iii) any provider agreement concerning workers' compensation, between the parties.
14.4 **Notices.** Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed given when delivered personally, placed in the U.S. mail (postage prepaid), delivered to a recognized courier service for delivery (delivery charges prepaid), or transmitted by electronic means and addressed to the last address furnished to the other party in writing. Until another address is furnished in writing, notice to HMO may be addressed to the address set forth below and notice to Provider may be addressed to the address set forth on the signature page of this Agreement.

Attn: Network Engagement – 5W392
Wellmark Health Plan of Iowa, Inc.
1331 Grand Avenue
Des Moines, IA 50309-2901
Email: ProviderContracting@wellmark.com

14.5 **Professional Judgment.** Provider shall exercise Provider's independent professional judgment in providing health care services. Nothing in this Agreement shall be construed to prohibit or otherwise restrict Provider, acting within the lawful scope of Provider's profession, from discussing with a Covered Person the Covered Person's health status and medical care or treatment options regardless of whether such medical care or treatment options are Covered Services.

14.6 **Severability.** In the event any provision of this Agreement is prohibited by or invalid under applicable law or determined invalid or unenforceable by a court of competent jurisdiction or any other governmental authority with jurisdiction over the parties hereto, such provision shall be ineffective to the extent of such prohibition, invalidity or unenforceability without invalidating the remainder of the provision or the remaining provisions of this Agreement.

14.7 **Headings; Recitals.** The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement. The Recitals are a part of this Agreement.

14.8 **Governing Law.** This Agreement has been entered into, and is performable in part, in Des Moines, Iowa. This Agreement shall be construed and enforced in accordance with the laws of the State of Iowa, but without regard to provisions thereof relating to conflicts of law.

14.9 **Amendment.** This Agreement may be amended from time to time. Except as expressly stated in this Agreement or hereinafter in this Section 14.9, no amendment will be effective unless duly executed in writing by HMO and Provider.

HMO shall provide written notice to Provider regarding any proposed amendment ninety (90) days in advance of the stated effective date of the proposed amendment (the “Amendment Notice”). If Provider objects to the amendment, Provider must, within sixty (60) days from the date the Amendment Notice was given to Provider, give written notice of termination of this Agreement to HMO. In such event, this Agreement shall terminate at the end of the ninety (90) day Amendment Notice period, unless HMO gives written notice to the objecting Provider within sixty-five (65) days of the date of the Amendment Notice that HMO will not implement, as to Provider, the amendment to which Provider objected. If Provider does not give written notice of termination of this Agreement to HMO within such sixty (60) day period, such amendment to this Agreement will become effective at the end of the ninety (90) day Amendment Notice period.

14.10 **Third-Party Beneficiary.** This Agreement is not a third-party beneficiary contract and shall not in any respect whatsoever increase the rights of Covered Persons or any other third party with respect to Provider or HMO or the duties of each of those parties or create any rights or remedies on behalf of Covered Persons against Provider or HMO.
14.11 **Consideration; Construction.** Provider and HMO agree that the mutual obligations contained herein constitute consideration for their respective obligations and that there shall not be any separate monetary compensation therefor. This Agreement shall not be construed more strongly against any party regardless of who was more responsible for its preparation.

14.12 **Survival.** The requirements contained in this Agreement that contemplate continued obligations of one or both of the parties, including, but not limited to Section 9.1, 10.1, 10.2, 10.5, 10.6, 10.7, 11.1, 11.2, 12.4, 14.8, 14.12 and 14.13, and the confidentiality and indemnification requirements under Exhibit C, shall survive any termination of this Agreement.

14.13 **Limitation of Action; Waiver of Jury Trial.** No legal or equitable action may be brought on any claim arising under this Agreement more than two (2) years after the cause of action arose. **HMO and Provider each irrevocably waives all right to trial by jury in any action, proceeding or counterclaim arising out of or relating to this Agreement.**

IN WITNESS WHEREOF, HMO and Provider have entered into this Agreement.

____________________________________________________________________
Print Legal Name of Provider

____________________________________________________________________
Social Security or Tax Identification Number

____________________________________________________________________
Street Address

____________________________________________________________________
City, State and Zip Code

Date of Execution by Provider ________________________  Signature ________________

____________________________________________________________________
Email Address

Wellmark Health Plan of Iowa, Inc.
1331 Grand Avenue
Des Moines, Iowa  50309-2901

By:  ______________________________________________________________
Laura Jackson
Executive Vice President, Wellmark, Inc.

Date of Acceptance by
Wellmark Health Plan of Iowa, Inc.
EXHIBIT A

to the
Wellmark Health Plan of Iowa, Inc.
Practitioner Services HMO Agreement

PAYMENT METHODOLOGY

The purpose of this Exhibit is to identify the terms and conditions by which HMO shall make payment to Provider for Covered Services under this Agreement. This Exhibit is an integral part of and subject to all of the terms and conditions of the Agreement. Except as provided herein, each of the terms defined in the Agreement shall have the same meaning when used in this Exhibit.

1. Definitions

1.1 "Maximum Allowable Fee" (MAF) for medical services and supplies means the fees established annually by HMO based upon any one or more of the following three (3) elements (as determined by HMO): (i) the Resource Based Relative Value System ("RBRVS") that includes Relative Value Units ("RVUs") times HMO-determined multipliers; (ii) statistically derived customary charge, based upon the same service when performed by a majority of providers with comparable skills and training within the State of Iowa or, as applicable, another state; and (iii) commercially available fee schedules, payment values and methods developed by HMO. Such annual revisions to the MAF will be provided or made available at least ninety (90) days prior to the effective date, and are not material changes to this Agreement (and do not require an amendment to this Agreement).

1.2 "Maximum Allowable Fee for Drugs" (MAFD) means the fees for therapeutic drugs established quarterly by HMO as follows: (i) for all CPT/HCPCS codes with a published CMS Average Sale Price, Average Sale Price times HMO-determined multipliers; (ii) for all CPT/HCPCS codes with no published CMS Average Sale Price, including unlisted CPT/HCPCS codes, median average wholesale price (the data source for which is determined by HMO) times HMO-determined multipliers; and (iii) for all remaining CPT/HCPCS codes, fees determined by HMO. The MAFD does not apply to drugs used in diagnostic procedures. Such quarterly revisions to the MAFD are not material changes to this Agreement (and do not require an amendment to this Agreement).

2. Payment

For claims incurred, Provider will be paid for Covered Services, less applicable deductibles, coinsurance and copayments, as follows: for medical services and supplies, the lesser of the Provider's billed charge or the MAF; for therapeutic drugs, the lesser of the Provider's billed charge or the MAFD. All payments to Provider are subject to the payment terms set forth on the secured provider section of HMO’s website (www.Wellmark.com) and the Provider Guide. HMO may establish and change from time to time the MAF and the MAFD for each Network described in Exhibit B.

3. Rural Health Clinics and Federally Qualified Health Centers (hawk-i only)

For any Provider facility that is recognized by Medicaid as a rural health clinic or a federally qualified health center that provides care to hawk-i Covered Persons, there will be a quarterly review of claims rendered at such facility to determine if a settlement is necessary. Beginning with services provided July 1, 2013, and after, HMO will calculate a quarterly HMO encounter rate using the number of hawk-i Covered Persons receiving care from Provider at the facility (as determined utilizing the tax identification number for Provider) and the total allowed amount received for those services. The HMO encounter rate will be compared to Provider’s Medicaid PPS rate. If HMO quarterly encounter rate is less than the Medicaid PPS
rate, Provider will receive payment for the difference between the HMO encounter rate and the Medicaid PPS per *hawk-i* Covered Person seen during that quarter. If the HMO encounter rate is calculated higher than Provider's Medicaid PPS rate (as determined utilizing the tax identification number for Provider), there will be no quarterly settlement made to Provider and HMO will not request a refund for that difference. Quarterly payments may take up to sixty days after the quarter ends to be processed and issued.

As an illustrative example of the quarterly calculation:

1. Thirty-five (35) *hawk-i* Covered Persons each had one visit during the July 1, through October 1, 2013 time period at Provider’s facility.
2. Facility’s Medicaid PPS rate is $93.00.
3. Total calculated amount for services to *hawk-i* Covered Persons during quarter is $2,800.
4. HMO’s encounter rate is $80.00 ($2,800 divided by 35 *hawk-i* visits).
5. Difference between Medicaid PPS rate and Wellmark’s encounter rate is $13.00.
6. Quarterly settlement: $455.00 ($13.00 times 35 visits).
EXHIBIT B

to the
Wellmark Health Plan of Iowa, Inc.
Practitioner Services HMO Agreement

WELLMARK NETWORKS

The purpose of this Exhibit is to identify the Networks to which this Agreement applies. This Exhibit is an integral part of and subject to all of the terms and conditions of the Agreement. Except as provided herein, each of the terms defined in the Agreement shall have the same meaning when used in this Exhibit. Non-material changes to this Exhibit B may be made from time to time by Wellmark without amendment of the Agreement or this Exhibit. Non-material changes include, but are not limited to, changes to the names of Networks or Products or the features of the Products.

This Agreement applies to all POS and HMO Networks for all POS and HMO Products, including but not limited to, the following:

Point of Service (POS) Network
Any Network that is used to support POS Products including, but not limited to, Blue Choice and the Blue Cross and Blue Shield Association Out-of-Area program (BlueCard POS). The POS Network may be referred to as Wellmark Blue POS

Health Maintenance Organization (HMO) Network
Any Network that is used to support HMO Products, including, but not limited to, Blue Access, Blue Advantage, and University of Iowa UIGradCare. The HMO Network may be referred to as Wellmark Blue HMO.
EXHIBIT C

to the

Wellmark Health Plan of Iowa, Inc.
Practitioner Services HMO Agreement

WEB-BASED ACCESS

The purpose of this Exhibit is to identify the terms and conditions by which HMO may provide Provider with secured access to HMO’s website or web-based applications maintained by HMO or on HMO’s behalf by its designee for the purpose of self service or for Provider to obtain information regarding eligibility and claims for Covered Persons. This Exhibit is an integral part of and subject to all of the terms and conditions of the Agreement. Except as provided herein, each of the terms defined in the Agreement shall have the same meaning when used in this Exhibit. Non-material changes to this Exhibit C may be made from time to time by HMO without amendment of the Agreement or this Exhibit.

1. This Exhibit applies to access made available by HMO to a Wellmark.com interactive web application and all information to which a party using such application (hereinafter described as “User”) may have access by utilizing Personal Identification Number(s) (“PINs”) and/or Security Password(s) provided by HMO. Provider shall identify and name a “Designated Security Coordinator” (“DSC”) who shall act as Provider’s contact person for receipt of notices or other information from HMO pertaining to this web-based access. The requirements regarding the designation and role of the DSC are further defined in the Terms and Conditions posted at HMO’s website (www.Wellmark.com).

2. Provider, on behalf of itself and its Users and other authorized designees, hereby (1) accepts and agrees to the Terms and Conditions, including, but not limited to, audit rights and confidentiality obligations, posted at HMO’s website (www.Wellmark.com); (2) agrees to ensure that its Users and any other authorized designees will abide by the Terms and Conditions; and (3) agrees to be responsible for any of the financial obligations of Users or other authorized designees arising under the Terms and Conditions or HMO’s security provisions related to accessing any information on HMO’s interactive web application (www.Wellmark.com) or other information on a system of records maintained by or on behalf of HMO.

3. Provider agrees to indemnify and hold HMO harmless for any loss, cost, or expense including but not limited to reasonable attorney’s fees related to the improper use of Wellmark.com, improper access to confidential information contained therein, the inappropriate release of any confidential information to any unauthorized individuals or entities, or other breach of this Exhibit C by Provider or User. Nothing in this Section 3 eliminates or reduces any other rights of indemnity (including any common law rights) the parties may have in connection with the Agreement.